

Congratulations on applying for licensure in the State of Arkansas!

Please feel free to contact the Board office with questions during the application process. It is important that correct and complete materials are submitted for your applications.

The second page of this packet is a checklist of all required application materials. This checklist is for you to use during this process.

Incomplete applications are kept on file for one year. **All application fees are non-refundable.**

All application materials, other than the National Board Part IV score, must be received by the Executive Director of the ASBCE with a postmark of no later than 45 days prior to the orientation date. The National Board Part IV score must be in the hands of the Executive Director of the ASBCE with the postmark no later than 7 days before the orientation date.

An approved applicant will be permitted to sit for the Arkansas State Board of Chiropractic Examiners orientation provided the applicant's date of graduation from Chiropractic College precedes the date of the next regularly-scheduled orientation by no more than six (6) months.

Updated Law:

ACA 17-81-308 (a)(5) – States, “Posses a valid National Board of Chiropractic Examiners certificate, to include **Parts I, II, III, and Part IV and the physiological therapeutics section;**”

ACA 17-81-305 (d) – Repealed 05/04/2016

Make checks/ money orders/ cashier checks payable to:

AR State Board of Chiropractic Examiners or ASBCE

Mail application and all paperwork to:

**AR State Board of Chiropractic Examiners or ASBCE
101 East Capitol Ave., Suite 209
Little Rock, Arkansas 72201**

Contact Information:

P: (501) 682-9015 / F: (501) 682-9016

website: www.arkansas.gov/asbce

email: ASBCE@arkansas.gov

APPLICATION CHECKLIST

Fees:

- _____ \$150 Application Fee
- _____ \$36.25 AR State & FBI Background Check Fee
- _____ \$50 Orientation Fee

Application:

- _____ Page 1 Application
- _____ Page 2 Background
- _____ Page 3 Education / NBCE
- _____ Page 4 Employment / Licensed in Another State / Chiropractic related Professional Licenses
- _____ Page 5 Certifying Statement
- _____ Page 6 Character Affidavit – 1 / Notarization
- _____ Page 7 Character Affidavit – 2 / Notarization
- _____ Page 8 Affirmation / Photo ID / Notarization

Criminal Background Check Application (not included in this packet)

- _____ Page 1-2 Verification Form / Notarization and fingerprint cards sealed by fingerprint technician / officer

Supplemental Paperwork:

- _____ License Verifications from Other States / Other Professions (*if applicable*) – page 4
- _____ Copy of Chiropractic Diploma
- _____ Official Chiropractic Transcript mailed directly from college. *Required: 120 classroom hours of physiological therapeutics and not less than 4,400 fifty minute resident class hours or not less than 4 years of 9 academic months.*
- _____ Official Undergraduate Transcript(s) mailed directly from college(s). *Required: Applicant must have not less than a total of 60 semester hour credits, of which a minimum of 30 semester hour credits must be in science subjects such as biology, zoology, chemistry, math, or other like subjects, with no less than a "C" average.*
- _____ Official National Board of Chiropractic Examiners transcript mailed directly from NBCE
- _____ Letter of Recommendation from a doctor with five (5) years experience. The recommendation must be on the doctor's letterhead. **This is separate from the character affidavit forms.**
- _____ Copy of Driver's License
- _____ Completed Jurisprudence Exam
- _____ Any Additional Information Provided on Separate Sheets



ARKANSAS STATE BOARD OF CHIROPRACTIC EXAMINERS

101 East Capitol Avenue, Suite 209, Little Rock, Arkansas, 72201

P: (501) 682-9015 / F: (501) 682-9016

www.arkansas.gov/asbce/ / ASBCE@arkansas.gov

Applying For:

Original License

Transfer of License

Reinstatement of
Lic. No. _____

APPLICATION FOR LICENSURE AND/OR EXAMINATION

PRINT OR TYPE ANSWERS TO ALL QUESTIONS ON THIS FORM IN FULL

Name:

FIRST	MIDDLE	LAST	MAIDEN/OTHER	SS#
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Address:

NUMBER AND STREET	CITY	STATE	ZIP	COUNTY	EMAIL
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HOME PHONE	CELL PHONE	DATE OF BIRTH	AGE	BIRTH CITY	BIRTH STATE	BIRTH COUNTRY
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___ M ___ S ___ D ___ W ___ M ___ F

MARITAL STATUS	GENDER	CITY OF RESIDENCE	COUNTY OF RESIDENCE
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___ White/Caucasian ___ Black/African American ___ American Indian

___ Alaska Native ___ Asian ___ Native HI/Pacific Islander

RACE

___ Non Hispanic/Non Latino ___ Hispanic/Latino

ETHNICITY

Military Service:

BRANCH	RANK	FROM	TO
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Please print exactly how you would like your name to read on your wall certificate when it is issued. Wall certificates will be printed as **{NAME}, D.C.**

WALL CERTIFICATE NAME

Act 1489 of 2009: This legislation requires Arkansas state agencies, boards and commissions that license health professions to procure and report demographic data to the Arkansas Minority Health Commission (AMHC), Arkansas Department of Health (ADH), and Arkansas Center for Health Improvement (ACHI).

EACH "YES" ANSWER MUST BE EXPLAINED IN DETAIL ON A SEPARATE PAGE.

	Yes	No
1. Has your application for examination or licensure ever been rejected in any State territory, province, or foreign country?		
2. Have you ever been the subject of any disciplinary action by any Government, jurisdictional or licensing Authority; Federal, State or Municipal, including, but not Limited to, having a malpractice action filed against you?		
3. Provide full disclosure to the Board of any criminal proceeding taken against the applicant including but not limited to (answer a-d): a. Having been arrested a) b. Pleading guilty, nolo contendere or receiving a conviction of a felony. b) c. Pleading guilty, nolo contendere or receiving a conviction of a misdemeanor involving moral turpitude. c) d. Pleading guilty, pleading nolo contendere or receiving a conviction for violation of federal or state controlled dangerous substance laws. d)		
4. Have you ever been addicted, currently addicted, to any chemical substance, including alcohol?		
5. Have you ever been treated for chemical substance addiction?		
6. Have any of the healing arts licenses you hold or have held ever been revoked, suspended, cancelled, denied, voluntary surrender, or voluntary lapse? If so please attach an explanation.		
7. How long have you been practicing chiropractic and where? _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Years Location </div>		
8. Do you claim to practice, or be qualified to practice, any method or system or healing other than chiropractic?		
9. Do you promise to support and agree to abide by the laws of the State of Arkansas, especially those pertaining to the practice of chiropractic, such as the Rules and Regulations, and Statutes, of the Board of Chiropractic Examiners, to conduct yourself ethically, honorably as a practitioner of chiropractic, and to observe the health laws and regulations of the State of Arkansas?		

LIST ALL EDUCATION BEGINNING WITH HIGH SCHOOL: Attach a separate page if necessary.

NAME OF INSTITUTION	CITY, STATE	FROM	TO	DEGREE RECEIVED
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CHIROPRACTIC COLLEGE	CITY, STATE	FROM	TO	DEGREE RECEIVED	GRADUATION DATE
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CHIROPRACTIC COLLEGE GRADUATION DATE

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NATIONAL BOARD OF CHIROPRACTIC EXAMINERS (NBCE) INFORMATION

	Yes	No
1. Will you be submitting a National Board Transcript?		
a. Part I		
b. Part II		
c. Part III		
d. Part IV		
e. Physiotherapy		
f. SPEC		
g. Acupuncture		
h. Ethics and Boundaries		

EMPLOYMENT: Account for ALL gaps of time in employment and/or education. Attach a separate page if necessary.

From	To	EMPLOYER	CITY, STATE	JOB TITLE/ACTIVITY

Proposed Practice

NAME	PHONE

ADDRESS	CITY	STATE	ZIP	COUNTY

Reason(s) for Practicing in Arkansas:

FOR CHIROPRACTIC PHYSICIANS LICENSED IN ANOTHER STATE, PLEASE ANSWER THE FOLLOWING:

Reason for Relocating to Arkansas:

Have you been actively engaged in the practice of chiropractic in another state, territory or province of the United States or Canada for a period of at least five (5) consecutive years immediately prior to making this application?

YES NO If yes, Full Time Part Time

Please have the licensing Board in the state, territory, or provinces in which you hold a license or have held a license submit a verification of licensure to the Board.

State(s)

CHIROPRACTIC RELATED LICENSES OR CERTIFICATES IN OTHER STATES: Attach a separate page if necessary.
Verifications from each State you hold or have held a license must be submitted.

PROFESSION	STATE OR COUNTRY	NUMBER	DATE ISSUED	CURRENT STATUS

CERTIFYING STATEMENT

Chiropractic Practice Experience

Graduating applicants: include information of clinical experience during last year of Chiropractic College, and any other experience obtained.

Licensed Chiropractors: list your practice experience and any other experience obtained.

I have had a minimum of _____ years and/or _____ months with verifiable chiropractic practice experience. Complete, detailed information relative to this experience is as follows:



Signature: _____

Date____/____

CHARACTER AFFIDAVIT - 1

A Licensed Chiropractor must sign these affidavits attesting the applicant to be a person of good moral character. The Licensed Chiropractor may not be related or under any financial obligations to the applicant.

This affidavit does not replace the Letter of Recommendation from a doctor with five (5) years experience and printed on his/her letterhead.

State of _____)
_____ County) } ss.

I, _____ of
Attester's Name

Clinic Name / Chiropractic College Name

being duly sworn, state that I am a legally qualified Chiropractor, holding unrevoked License No. _____,
practicing Chiropractic in the State of _____, that I know
_____ to be of good moral character.

Applicant's Name

_____, D.C.
Signature

Subscribed in my presence and sworn to before me, this the _____ day of _____, 20____

State _____ County _____

(SEAL) Notary Public _____

My Commission Expires _____

Commission # _____

A Licensed Chiropractor must sign these affidavits attesting the applicant to be a person of good moral character. The Licensed Chiropractor may not be related or under any financial obligations to the applicant.

State of _____)
_____) } ss.

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APPLICANT'S AFFIRMATION

"I hereby certify under oath or affirm that I am the person named in this application; that all statements I have made herein are true; that the photograph is a true resemblance of me and was made within the last twelve (12) months; that in consideration of the issuance to me of a license to practice chiropractic in the State of Arkansas I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice, from immoral, unprofessional and unethical conduct; that I shall abstain from professional association with, and shall not act as a shield for, an unlicensed practitioner or other person. I hereby agree that violation of this pledge shall constitute cause for revocation of my chiropractic license. I further swear/affirm that I have not practiced chiropractic in any other state, territory, or province of the United States in violation of the laws thereof; that my license to practice chiropractic has not been revoked in any other state, territory, or province; and that I have not pled guilty, nolo contendere or received a conviction for a felony, for a misdemeanor involving moral turpitude, or violation of federal or state controlled substance laws. I further state that I am not omitting any information, which might be of value to the Board to determine my qualifications or eligibility. I agree that any falsification, omission or withholding of pertinent information or facts, concerning my qualifications as an applicant for examination and/or licensure shall be sufficient to bar me from further consideration for licensure by the Arkansas State Board of Chiropractic Examiners. Any such falsification, omission, or withholding of pertinent information shall serve as sufficient grounds for fines, revocation, cancellation or suspension of my chiropractic license should it be discovered after my license is granted. I hereby authorize all institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies (local, state, federal, or foreign) to release to the Arkansas State Board of Chiropractic Examiners or its successors any information, files, or records requested by the Arkansas State Board of Chiropractic Examiners in connection with this application. **By submitting this application, I authorize the release of any records from a state and FBI background check, disciplinary actions from any organizations, institutions, clinics or hospitals to the Arkansas State Board of Chiropractic Examiners.** I further authorize the Arkansas State Board of Chiropractic Examiners or its successors to release to the organizations, individuals or groups listed herein, information, which is material to this application or any subsequent license."

Signature: _____

Date ____/____/____

Staple or tape here

PHOTO

taken within the past 12 months,
on photo paper. Preferably a
passport photo.

This is to certify that the photograph is a correct likeness of the applicant, and the statement signature and date is that of the applicant completing this application.

Subscribed in my presence and sworn to before me, this the ____ day of ____, 20____

State ____ County ____

(SEAL) Notary Public _____

My Commission Expires _____

Commission # _____